REQUIRED ELEMENTS:

Start date and monthly review dates with case managers initials. The Specific Target Behavior(s) is to be outlined with corresponding Frequency/Duration/Intensity of behavior, as well as the Antecedents. The Goal/Desired Outcome with specific Objective(s), noting anticipated duration and date achieved. Interventions are to specify the role of the client, parent/caregiver, TBS coach, specialty mental health provider, and any support staff.

The next section of the Treatment Plan shall concentrate on the client's strengths and a proposed transition plan. The overall outcome goal shall be identified at the onset and a notation shall be made with the progression of treatment if the goal has been achieved, with an explanation when it is not. The coach start date and anticipated discharge date shall be noted. The Treatment Plan shall record the TBS hours of service noting the date, days and times of service, total hours, and reason for changes in service hours.

All signatures of those in attendance at the TBS team meetings are desired. The following are required signatures:

1. Client
2. Parent/Guardian (caretaker)
3. Specialty Mental Health Provider – SMHP (therapist)
4. TBS Case Manager – Contractor
5. TBS Facilitator – County
6. TBS Coach(s)

The T bar shall be completed with the client's name, InSyst number, and program name.

BILLING:

<u>Billing for writing, updating, or amending a Treatment Plan shall only occur when it is connected to a direct client service.</u> Document the service provided on the appropriate progress note (see Progress Note section), utilizing the appropriate billing code. A billing record shall be completed (see Billing portion of Progress Note section).

When writing, updating or amending a Treatment Plan that is not connected to a direct client service, document that work on a progress note and utilize a non billable code with a corresponding billing record.

Start Date:_____ Monthly Review Date 1: _____ Monthly Review Date 2: _____

CM Initials: _____ CM Initials: _____

Specific Target Behavior #: _____: _____

Frequency/Duration/Intensity of Behavior: _____

Antecedents: _____

Goal/Desired Outcome: _____

Objective 1: _____

Anticipated Duration: _____ Date Achieved: _____

Objective 2: _____

Anticipated Duration: _____ Date Achieved: _____

Objective 3: _____

Anticipated Duration: _____ Date Achieved: _____

Interventions:

Client will: _____

Parent/Caregiver will: _____

Coach will: _____

Specialty Mental Health Provider (SMHP) will: _____

Support Staff will: _____

Client Strengths: _____

Transition Plan: _____

Outcome Goal (identify)	Achieved	Explanation (if No or N/A):
☐ Avoid psychiatric hospitalization	☐ Yes ☐ No ☐ N/A	
☐ Prevent higher level of care	☐ Yes ☐ No ☐ N/A	
☐ Move to lower level of care	☐ Yes ☐ No ☐ N/A	

Coach Start Date: _____

Anticipated Discharge Date: _____

TBS Hours Date:	Days and Times:	Total Hours:	Reason for Change

Signatures:

Client:_____ Date:_____ Parent/Guardian:_____ Date:_____

SMHP:_____ Date:_____ Staff/Caregiver: _____ Date:_____

County TBS:_____ Date:_____ HHSA/CWS:_____ Date:_____

TBS Case Manager: _____ Date:_____ Other:_____ Date:_____

TBS Coach:_____ Date:_____ Other: _____ Date:_____

Other:_____ Date:_____ Other: _____ Date:_____

INITIAL DAY PROGRAM REQUEST
CONTINUED DAY PROGRAM REQUEST
SPECIALTY MENTAL HEALTH SERVICES DPR
Day Programs & Ancillary Services

NOTE:

Forms are generated by United Behavioral Health (UBH) which became the Point of Authorization for Day Intensive and Day Rehabilitation Programs (Half or Full) on 01-01-03. Outpatient Mental Health Services (MHS) offered on the same day (ancillary services) must also be authorized by UBH, with the CMBR component still subject to outpatient Utilization Review (UR). Medication only cases, TBS, and unplanned services such as Crisis Intervention (CI) are excluded from the UBH and UR authorization process.

In circumstances where retroactive authorization is needed, it may be granted through UBH. State DMH will not accept claims that are over one year old, and it takes up to 3 months for services to clear the system and be claimed. Thus, retroactive authorization should not be requested for services more than 9 months in the past.

Day Program Request has replaced the requirement for quarterly reports for AB2726 clients. However, clients placed through Child Welfare continue to require a quarterly report to be completed and submitted to the Child Welfare Worker.

WHEN:

- Prior authorization is required for Day Programs that occur more than five days per week.
- Initial authorization for Day Programs (and therefore ancillary programs) must be obtained by the seventh visit or twenty days after the Day Provider opens a client episode in InSyst.
- **Day Intensive must be re-authorized every three months.** Utilizing the Continued Day Program Request Form. Submitted to UBH at least 15 days before previous authorization expires.
- **Day Rehabilitation must be re-authorized every six months.** Submitted to UBH at least 15 days before previous authorization expires.
- Outpatient providers (ancillary services) treating a client who is enrolled in a Day Program must obtain authorization through the Day Program Provider. Authorization is only required for Mental Health Services (not for Medication Support, TBS, Crisis Intervention, or CMBR which follow outpatient UR procedures). Ancillary providers must submit the Specialty Mental Health Services DPR Form to the Day Provider at least fifteen days prior to the end of the previous authorization so all forms can be submitted to UBH.

ON WHOM:

All day program clients.

Outpatient (ancillary services) clients who are simultaneously enrolled in a Day Program obtain authorization through the Day Provider (until the client leaves the day treatment program). All providers are to ensure no duplication of service occurs.

COMPLETED BY:

Request submitted by: MD, Clinical or waivered Psychologist, licensed or waivered LCSW, licensed or waivered MFT, RN (with Masters Degree and psychiatric specialty), or trainee with co-signature by LPHA.

MODE OF COMPLETION:

Legibly handwritten, typed, or word-processed on most current UBH form(s). Authorization request forms are available on line at www.ubhpublicsector.com/sandiego/sdforms.htm

REQUIRED ELEMENTS:

Staff requesting services must complete all sections of the form that correspond with the requested authorization period.

Initial Day Program Request (DPR):

- Client Information
- Day Program Information
- Day Program Service Necessity Criteria
- Client Information
- Required Attachments: SMHS-DPR form when client receives ancillary services
- Signatures

Continued Day Program Request (DPR):

- Client Information
- Day Program Information
- History
- Day Program Service Necessity Criteria
- Client Information
- Client Areas of Strength
- Treatment Goals
- Medications
- Required Attachments: SMHS-DPR form when client receives ancillary services
- Signatures

Specialty Mental Health Services (SMHS-DPR):

- Client Information
- Day Program Information
- Specialty Mental Health Services program Information
- Type of Services and Frequency
- Adult, Child and Youth Ancillary Service Necessity Criteria
- Signatures

BILLING:

Payment Authorization is a non-billable activity, and is considered an administrative function. Therefore, there is no billing for preparation of the form.

This form should be used to request initial authorization of payment for **Day Program services.**	**County of San Diego Mental Health Plan** **Initial Day Program Request** RECEIVED by UBH:	fax/mail to: **United Behavioral Health, 3111 Camino del Rio North, suite 500 San Diego, CA 92108 Fax: (619) 641-6802 Phone: (800) 798-2254, option #2**

CLIENT INFORMATION ****CONFIDENTIAL****

Client Name: (*First & Last*)	Client InSyst #:	Date of Birth

DAY PROGRAM INFORMATION

Day Program Name: *Please print clearly*

_____ Phone: :_____ Day Program RU# _____

Date client began in Day Program ____/____ mm/yyyy Anticipated Date of Discharge ____/____ mm/yyyy

INITIAL AUTHORIZATION REQUEST: ☐ Intensive Day Treatment ☐ Day Rehab Frequency : _____ days a week

Begin Date for this Request: ___/___/____ mm/dd/yyyy End Date for this Request: ___/___/____ mm/dd/yyyy

DAY PROGRAM SERVICE NECESSITY CRITERIA **COMPLETE DIAGNOSIS and CHECK ALL CRITERIA THAT APPLY**

DIAGNOSIS ***TIP:*** Use **DSM-IV** Codes; include all Axes. **Client must also meet Title 9 Medical Necessity Criteria**

Axis I - Primary _____ **Axis II** -_____ **Axis III** - _____

Secondary _____

Axis IV _____ **Axis V** (*GAF*) Current _____ **Highest in last 12 months**_____

For adult clients only: Day Program Services Medical Necessity #_____ (Please review Day Program Medical Necessity Grid to determine this number)

SERVICE NECESSITY CRITERIA

1) Client exhibits an impairment in functioning due to the above diagnosis as evidenced by one or more of the following:

A. ☐ Substantial impairment in living arrangement, daily activities, social relationships, and/or age appropriate ADL skills as demonstrated by: (describe) _____

_____

B. ☐ Risk factors such as recurring psychotic symptoms, suicidal or homicidal ideation, without evidence of plan, or other violent ideation or behavior as demonstrated by:(describe) _____

_____

C. ☐ Demonstrative history that without day program services there is a substantial risk of recurrence of A. or B. (describe behavior/history supporting risk.)_____

_____

D. ☐ *(For children/youth)* Probability that child will not progress developmentally as individually appropriate, or will deteriorate developmentally as demonstrated by: _____

_____

2)☐ Client (and family for children) has been in, or is currently in lower level of care and the client has not demonstrated progress or stabilization (describe progress or lack of progress)_____

_____

3)☐ Client requires structured Day Program in order to move successfully from higher level of care to lower level of care or to prevent deterioration in functioning and admission to a higher level of care. (describe how is this determined)_____

_____

4)☐ Present living situation and functioning indicate need for structured day program. Describe living situation & functioning that supports need for Day Program._____

_____

5)☐ *(For children/youth)* Recent troubling life events, such as a change of placement, arrest and incarceration, or child abuse. (Describe behaviors/functioning indicating need for Day Program. A formal assessment must confirm medical necessity within 30 days after admission.)_____

CLIENT INFORMATION ****CONFIDENTIAL****		
Client Name: (*First & Last*)	Client InSyst #:	Date of Birth

REQUIRED ATTACHMENTS

PLEASE SUBMIT THE FOLLOWING DOCUMENT WITH THIS INITIAL DAY PROGRAM REQUEST:

☐ Specialty Mental Health Services DPR if the client receives ancillary services in addition to Day Program Services.

Day Program Clinician: (print)_____ Date:_____

Countersignature by Licensed Clinician:_____ Date:_____

For UBH Disposition Only: DOCUMENT AUTHORIZATIONS FOR DAY PROGRAM and ANCILLARY SERVICES

UBH Clinician eCura #:_____ Day Program Authorization Period: Begin Date:_____ End Date:_____

Approved # Days:_____ Frequency (# times/week) _____ Review Date:_____ Circle approved AS on next page(s) Logged ☐

Reduce DP Request:☐ Deny DP Request:☐ Date NOA-B Sent: _____ Reduce AS Request:☐ Deny AS Request:☐ Date NOA-B Sent:_____

Date DP Auths Entered:_____ **Date AS Auths Entered:**_____ **D/E Name:**_____ **Logged** ☐

This form should be used to request *continued authorization* of payment for Day Program services	**County of San Diego Mental Health Plan** ***CONTINUED* Day Program Request** RECEIVED by UBH:	mail to: **United Behavioral Health, 3111 Camino del Rio North, Suite 500 San Diego, CA 92108** **Fax: (619) 641-6802** **Phone: (800) 798-2254, option #2**

CLIENT INFORMATION ****CONFIDENTIAL****

Client Name: (*First & Last*)	Client InSyst #	Date of Birth

DAY PROGRAM INFORMATION

Day Program Name: *Please print clearly*

_____ Phone:_____ Day Program RU# _____

Date first began Day Program ____/____ (mm/yyyy) Anticipated Discharge Date ____/____ (mm/yyyy) Current Session Frequency : _____ days a week

CONTINUED AUTHORIZATION REQUEST: ☐ Intensive Day Treatment ☐ Day Rehab Frequency : _____ days a week

Begin Date for this Request: ___/___/___ (mm/ dd/ yyyy) End Date for this Request: ___/___/___ (mm/ dd/ yyyy)

HISTORY

☐ **Significant Life Events Since Last Review :**

_____

DAY PROGRAM SERVICE NECESSITY CRITERIA **COMPLETE DIAGNOSIS and CHECK ALL THAT APPLY**

DIAGNOSIS *TIP:* Use **DSM-IV** Codes; include all Axes. **Client must also meet Title 9 Medical Necessity Criteria**

Axis I - Primary _____ **Axis II** -_____ **Axis III** - _____

Secondary _____

Axis IV _____ **Axis V** (*GAF*) Current _____ **Highest in last 12 months**_____

For adult clients only: Day Program Services Medical Necessity #_____ (Please review Day Program Medical Necessity Grid to determine this number)

SERVICE NECESSITY CRITERIA

1) Client exhibits an impairment in functioning due to the above diagnosis as demonstrated by one or more of the following:

A. ☐ Substantial impairment in living arrangement, daily activities, social relationships, and/or age appropriate ADL skills as demonstrated by: (describe)_____

_____

B. ☐ Risk factors such as recurring psychotic symptoms, suicidal or homicidal ideation without evidence of plan, or other violent ideation or behavior as demonstrated by: (describe) _____

_____

C. ☐ Demonstrative history that without day program services there is a substantial risk of recurrence of A. or B. (describe behavior/history supporting risk.)_____

_____

D. ☐ *(For children/youth* Probability that child will not progress developmentally as individually appropriate or will deteriorate developmentally as demonstrated by:_____

2) ☐ Client (and family for children) has been in, or is currently in lower level of care and the client has not demonstrated progress or stabilization (describe progress or lack of progress)_____

_____

3) ☐ Client requires structured Day Program in order to move successfully from higher level of care to lower level of care or to prevent deterioration in functioning and admission to a higher level of care. (describe how is this determined)_____

_____

4) ☐ Present living situation and functioning indicate need for structured day program. Describe living situation & functioning that supports need for Day Program. _____

_____

5) ☐ Current treatment goals have not been met. There is progress toward treatment goals or a reasonable expectation that progress will be made during the next authorization cycle. _____

Revised: 01/21/05

CLIENT INFORMATION ****CONFIDENTIAL****		
Client Name: (*First & Last*)	Client InSyst #:	Date of Birth

CLIENT AREAS of STRENGTH	DESCRIBE STRENGTHS IN DETAIL (For children, include family strengths)
Job, School, Daily Activities	
Relationships, Family, Social Supports	
Social Activities, Interests	

TREATMENT GOALS: List goals directed at improving functioning. **Progress Rating Scale: N – New Goal, 1 – Much worse, 2 – Somewhat worse, 3 – No change, 4 – Slight improvement, 5 – Great improvement, R – Resolved**

Measurable Behavioral Goal:	As Demonstrated by:	Method(s) for Achieving Goal	Progress since last report

Client received psychiatric evaluation? ☐ Yes ☐ No **NAME OF PSYCHIATRIST**

CURRENT MEDICATIONS	Current Dose	CURRENT MEDICATIONS	Current Dose

REQUIRED ATTACHMENTS

PLEASE SUBMIT THE FOLLOWING DOCUMENT WITH THIS CONTINUING DAY PROGRAM REQUEST:

☐ Specialty Mental Health Services DPR if the client receives ancillary services in addition to Day Program Services.

Day Program Clinician: (print) _____ Date: _____

Countersignature by Licensed Clinician: _____ Date: _____

For UBH Disposition Only: DOCUMENT AUTHORIZATIONS FOR DAY PROGRAM and ANCILLARY SERVICES

UBH Clinician eCura #:_____ Day Program Authorization Period: Begin Date:_____ End Date:_____

Approved # Days:_____ Frequency (# times/week) _____ Review Date:_____ Circle approved AS on next page(s) Logged ☐

Reduce DP Request:☐ Deny DP Request:☐ Date NOA-B Sent: _____ Reduce AS Request:☐ Deny AS Request:☐ Date NOA-B Sent:_____

Date DP Auths Entered:_____ **Date AS Auths Entered:**_____ **D/E Name:**_____ **Logged** ☐

This form should be used to request authorization of payment for **Specialty Mental Health Services.**	**County of San Diego Mental Health Plan** **Specialty Mental Health Services DPR** RECEIVED by UBH:	**Form must be submitted to UBH by client's Day Program provider. UBH cannot accept this form if submitted by Specialty Mental Health Services Provider**

CLIENT INFORMATION ****CONFIDENTIAL****

Client Name: (*First & Last*)	Client InSyst #:	Date of Birth

DAY PROGRAM INFORMATION

Day Program Name: *Please print clearly*

_____ Phone: :_____ Day Program RU# _____

SPECIALTY MENTAL HEALTH SERVICES PROGRAM INFORMATION

Specialty Mental Health Program Name: *Please print clearly*

_____ Phone: :_____ Program RU# _____

REQUEST FOR AUTHORIZATION of Specialty Mental Health Services delivered by Organizational County Contracted providers on the same day as Day Program Services.

*** Treatment must include coordination with the other professionals treating client. Authorization is required only for ancillary services delivered on the same day client receives Day Program Services. Ancillary Services delivered to client in an Intensive Day Program require continued authorization within 3 months or 13 weeks. Ancillary Services delivered to client in a Day Rehab program require continued authorization within 6 months or 26 weeks. Medication Management, Case Management, TBS, and Crisis Intervention Services do not require authorization. ***

Complete the request by writing the # of visits requested per week (or month) and the # of weeks (or months) within which the visits will occur.

Service(s)	Frequency	Service(s)	Frequency
☐ Individual Mental Health Services	_____ visit(s) per _____week _____month for _____weeks _____months	☐ Group Mental Health Services	_____ visit(s) per _____week _____month for _____weeks _____months
☐ Collateral Mental Health Services	_____ visit(s) per _____week _____month for _____weeks _____months	☐ Collateral Mental Health Services	_____ visit(s) per _____week _____month for _____weeks _____months
☐ Other Mental Health Services (describe)_____	visit(s) per _____week _____month for_____weeks_____months	☐ Other Mental Health Services (describe)_____	___ visit(s) per _____week _____month for_____weeks_____months

Community services/self help do not require authorization but must be coordinated comprehensively with all mental health and psychosocial rehab services.

Community services/self help (please list) _____

ADULT/OLDER ADULT Ancillary Service Necessity Criteria: CHECK ALL THAT APPLY and complete description.

☐ The client is unable to receive these services while attending the Day Rehabilitation program due to client's specific clinical needs or family/caregiver needs. (Describe needs) _____

☐ Client transition issues make these services necessary for a time limited interval. (Describe why transition services are needed and length of interval) _____

☐ These concurrent services are essential to coordination of care. (Describe why services are essential for coordination) _____

CHILD and YOUTH Ancillary Service Necessity Criteria: CHECK ALL THAT APPLY and complete description.

☐ Requested service(s) is not available through the day program. (Describe why service is not available through day program) _____

☐ Continuity or transition issues make these services necessary for a time limited interval. (Describe why transition services are needed and time interval) _____

☐ These concurrent services are essential to coordination of care. (Describe why services are essential for coordination) _____

End date of previous authorization: ____/_____ MM/YYYY Start date of this authorization: ____/_____ MM/YYYY End date of this authorization: ____/_____ MM/YYYY

Name of Ancillary Services

Clinician requesting authorization: (print)_____ **Phone:**_____ **Date:**_____

Countersignature by Licensed Clinician:_____ **Phone:**_____ **Date:**_____

Revised: 01/21/05

UTILIZATION REVIEW REQUEST AND AUTHORIZATION
Outpatient Treatment & Case Management Programs
Implemented 02-01-04

WHEN:

Up to thirty days prior to an outpatient client reaching the six-month mark from the date of current episode opening to the program. Subsequently, the Utilization Review (UR) form shall be completed up to thirty days prior to the expiration of the previous UR Authorization.

ON WHOM:

All outpatient and case management clients meeting above requirements. This excludes medication only cases, Therapeutic Behavioral Services, and unplanned services such as Crisis Intervention (CI).

Clients who are simultaneously enrolled in a Day Program obtain authorization through the Day Provider (until the client leaves the day treatment program). Case Management services are not authorized through the Day Program and therefore such services must be authorized through the program's UR process.

COMPLETED BY:

Request submitted by: MD, clinical or waivered Psychologist, licensed or waivered LCSW/ MFT, RN, trainee, QMHP, rehab specialist, rehab staff, or paraprofessional. The program sets co-signature requirements.

UR Committee member completes the disposition section. UR Committee member who approves the UR form shall be a licensed or waivered clinician. The Committee member signing the UR form cannot be the same as the staff who submitted the UR request.

MODE OF COMPLETION:

Legibly handwritten, typed, or word-processed on Utilization Review Request and Authorization – Outpatient Treatment form (MHS-662).

REQUIRED ELEMENTS:

Staff requesting services outline the date of initial admission in the program, type of services offered by program, current planned session frequency per month, and any additional comments. A five-axis diagnosis shall be completed. Note if family is involved in treatment, and if youth or family are requesting continuation of service. Check off any concurrent interventions treatment client is involved with, and any prior hospitalizations.

Staff requesting services complete the current functioning section, identifying symptoms in the quadrant model. The next section focuses on client information providing a progress update, current participation and any medication changes/issues or general changes/issues.

Staff requesting services shall summarize the Child / Adolescent Measurement System (CAMS) results; indicating date measure was administered. The first five are required scales (acuity, functional impairment, hopefulness, social competence, symptomatology-behavioral functioning), with the sixth scale (victimization) being optional. Indicate when CAMS are not completed with rationale.

Staff requesting services identify all the proposed treatment modalities with the planned frequency. The expected outcome and prognosis follows. The requesting staff then outlines the actual requested numbers of months to continue providing services after the six-month mark from episode opening or previous UR authorization.

The requesting staff attaches a NEW Client Plan (with or without the client's and guardian's signature), prints, signs, and dates the request. Each program determines co-signature requirements. **A NEW CLIENT PLAN MUST BE SUBMITTED TO THE UR COMMITTEE WITH THE UR REQUEST FORM.**

The UR Committee representative identifies the approved number of months post the six-month mark from episode opening or previous UR authorization. The UR representative specifies the beginning and end date of the authorization period. They check the appropriate box indicating if the request was approved, reduced, or denied. UR committee representative may outline any comments or suggestions to the requesting staff. When authorization is granted retroactively it shall be indicated with rationale. The UR committee representative prints name, signs, and dates the form. Note when original form was placed in file, a copy was provided to the staff who submitted the request and that information was logged on UR Committee Minutes form. Finally, the UR committee representative completes the front top right hand portion of the form, outlining date of review and date of last review when applicable.

The T bar shall be completed with the client's name, InSyst #, and program name.

BILLING:

Utilization Review is a non-billable activity. Therefore, there is no billing for preparation of the UR form or for the UR Committee time spent on reviewing the case. UR is an administrative function.

NOTE:

Outpatient providers are expected to implement UR in a timely manner following the guidelines set forth in the Outpatient Utilization Review Policy and Procedure No. 06-01-118. Failing to do so is a serious contract violation. A current authorization must be in place for each client in an outpatient setting receiving services after the initial six-month period. In the rare instance where UR could not be obtained prior to the rendering of services, it may be obtained retroactively. Provider's implementation of retroactive authorization is subject to QI and Program Monitor review and corrective action.

The program shall maintain UR Committee Minutes form, attaching copy of each UR request reviewed.

UTILIZATION REVIEW REQUEST AND AUTHORIZATION
Outpatient Treatment

Date Reviewed: _____

Date of Last Review: _____

Date Initial Admission: _____

Type of Services: ☐MHS ☐MHS-R ☐CM ☐Meds

Current Planned Session Frequency:

☐ _____ session/s per month for _____

☐ Comments:

DSM IV – TR **Axis I** – Primary: _____ Code: _____

Secondary: _____ Code: _____

Other: _____ Code: _____

Axis II - _____ Code: _____

Axis III - _____ Code: _____

Axis IV - ☐ Primary Support Group ☐ Social Environment ☐Educational ☐Occupational ☐Housing ☐Economic ☐Access to Health Care ☐Interaction with the Legal System ☐Other psychosocial and Environmental Problems

Axis V - (*GAF*) Current: _____ **Highest in last 12 months:** _____

Is Family Involved with Treatment? Y N (*If no please explain):* _____

Does youth and/or family request continuation of service? Y N (*Comments*): _____

Concurrent Interventions: (*Please Check off all that apply*): ☐TBS ☐Day Treatment Intensive ☐Day Treatment Rehabilitation ☐Chemical Dependency ☐Rehabilitation ☐Other Outpatient (*Please Specify*): _____

Prior Hospitalizations: Y N (*If yes please specify how long ago*): ☐past month ☐past 3 months ☐past 6 months ☐past year ☐more than one year

CURRENT FUNCTIONING

	Quadrant 1	Quadrant 2	Quadrant 3	Quadrant 4
Actively	☐Suicidal ☐ Fire Setting ☐Homicidal ☐Psychotic			☐None
School	☐Expelled ☐Increased Placement Level ☐Chronic Truancy ☐Threats to Staff or Students ☐Major Property Damage	☐Failure ☐ Significant Decline ☐ Frequent Truancy/Non-Excused Absences ☐ Frequently Disruptive	☐Declining Grades ☐ Poor Attention ☐ Periodic Behavior Problems ☐ Producing Less Than Expected Level	☐Regular Attendance ☐Minimal Behavior Problems
Home	☐Threats to Family Members ☐AWOL/Running Away ☐Severe Property Damage ☐Serious and Repeated Violations of Rules/Laws	☐Overnight Running Away ☐Moderate Property Damage ☐Persistent Failure to Comply with Reasonable Rules	☐Episodic Property Damage ☐Frequent Disobedience and/or Resistance	☐Occasional Disobedience
Thinking	☐Active Thought Disorder ☐Dissociation ☐Disorientation	☐Disorganized Communication ☐Distortion of Thinking ☐Occasional Reality Impairment (Suspicions/Obsessions)	☐Odd Beliefs ☐Unusual Perceptions ☐Eccentric	☐No disturbance in Thinking ☐Normal Concerns
Substance	☐Dependence ☐Frequently Intoxicated or High (More than twice per week)	☐Abuse with Interference of Functioning	☐Recurrent Use with Minimal Interference of Functioning	☐Occasional ☐ No Use ☐Full Remission
Mood	☐Persistent and Incapacitating	☐Intense and Abrupt Episodes ☐Marked Mood Changes ☐Blunt Affect ☐ Significantly Withdrawn/Isolative	☐Anxious ☐ Self Critical ☐ Fearful/Sad with Overt Sx ☐ Low Self Esteem ☐ Easily Distressed ☐ Restricted Affect	☐Normal Reactions to Life Events ☐Expresses Emotions Appropriately
Self Harm	☐Active Clear Plan ☐Serious Self Harm	☐Superficial Cuts ☐Suicidal Ideation without Immediate Danger	☐Fleeting Suicidal Ideation ☐Pinching/Scratching Self	☐None
Behavior Toward Others	☐Serious Intent to Cause Harm ☐Seriously Assaultive ☐Serious Repeated Criminal Activity	☐Threats to others ☐Some Aggressive Behaviors ☐Inappropriate Sexual Behavior ☐ Police Involvement	☐Argumentative ☐ Occasional Tantrums ☐ Ignored/Rejected by Peers ☐ Poor Social Skills ☐ Assault History	☐Age Appropriate Behavior
Other				

CLIENT INFORMATION

Progress Update:	**Current Participation:**	**Medication Changes/Issues:**
☐ Progressing and Improving	☐ Regular Attendance	
☐ Some Progress, Remains at Risk	☐ Occasionally Missed Sessions	
☐ Minimal Progress or Improvement	☐ Frequently Missed Sessions	**Other Changes/Issues:**
☐ Not Progressing	☐	
☐		

Child / Adolescent Measurement System (CAMS) Date CAMS Administered: _____

Acuity Score: _____ Functional Impairment Score: _____ Hopefulness Score: _____

Social Competence Scale: _____ Symptomatology-Behavioral Functioning Scale: _____ Victimization Scale: _____

☐CAMS not completed Reason: _____

Proposed Treatment Modalities	**Planned Frequency**	**Expected Outcome and Prognosis**	**REQUESTED NUMBER OF MONTHS**
☐ Case Management/Brokerage	_____ session(s) per month	☐ Return to full functioning	
☐ Mental Health Services - Collateral	_____ session(s) per month	☐ Expect improvement, anticipate less than full functioning	
☐ MHS – Individual	_____ session(s) per month	☐ Relieve acute symptoms, return to baseline functioning	
☐ MHS – Group	_____ session(s) per month	☐ Maintain current status/prevent deterioration	
☐ MHS – Family	_____ session(s) per month	☐	
☐ MHS – Rehab	_____ session(s) per month		
☐ Medication Support	_____ session(s) per month		

Requesting Staff's Name: _____ **Date:** _____

Requesting Staff's Signature: _____ **Date:** _____

Co- Signature: _____ **Date:** _____

INCLUDE NEW CLIENT PLAN WHEN SUBMITTING TO COMMITTEE

UR COMMITTEE DISPOSITION:

Approved # of Months: _____ **AUTHORIZATION PERIOD** Beginning Date: _____ End Date: _____

☐Request Approved ☐Request Reduced ☐Request Denied

Comments/Suggestions: _____

_____

☐Retroactive Authorization _____

UR Clinician's Name: _____ Signature: _____ Date: _____

☐Original in file ☐Copy to requester ☐Logged on UR Committee Minutes

Utilization Review Committee Minutes

Attach Copies of UR Requests submitted to Committee

Program Name: ______________________________ **Date:** ____________

Committee Members, Credentials: **Signature:**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Log of clients reviewed: **Disposition:**

Log of clients reviewed	Disposition
	☐Request Approved ☐Request Reduced ☐Request Denied
	☐Request Approved ☐Request Reduced ☐Request Denied
	☐Request Approved ☐Request Reduced ☐Request Denied
	☐Request Approved ☐Request Reduced ☐Request Denied
	☐Request Approved ☐Request Reduced ☐Request Denied
	☐Request Approved ☐Request Reduced ☐Request Denied
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	☐Request Approved ☐Request Reduced ☐Request Denied
	☐Request Approved ☐Request Reduced ☐Request Denied
	☐Request Approved ☐Request Reduced ☐Request Denied

SECTION V

PROGRESS NOTES

PROGRESS NOTES

WHEN: Upon provision of services.

ON WHOM: All Clients with open cases, receiving services.

COMPLETED BY:

Group Progress Note (MHS-924)
MD acting as the primary therapist, licensed or waivered Clinical Psychologist, licensed, registered, or waivered LCSW, licensed, registered or waivered MFT or RN (with Masters Degree and psychiatric specialty), and Trainees with co-signature by an LPHA or LPHA waived. Specifically for mental health services in the form of group session.

Individual/Family Progress Note (MHS-925)
MD acting as the primary therapist, licensed or waivered Clinical Psychologist, licensed, registered, or waivered LCSW, licensed, registered or waivered MFT or RN (with Masters Degree and psychiatric specialty), and Trainees with co-signature by an LPHA or LPHA waived. Specifically for mental health services in the form of individual and family session.

Progress Note – Other Services (MHS-926)
All service providers, acting within their scope of practice.
Specifically for case management / brokerage, rehabilitation, and collateral contacts such as Treatment Team.
RN shall utilize this form when not performing psychotherapy.
MD shall utilize this form for contacts that are not appropriate for the Psychiatric / Medication Evaluation or Medication Follow Up form (see Medical Section for additional information).

Utilize this form for groups facilitated by Rehabilitation Staff, Rehabilitation Specialists, and Para Professional – must include group formula for billing. (Total Time) x (Number of Staff) / (Number of Clients) = (Total Time per Client). To get total time per staff, divide total by number of staff.

TBS Progress Note (MHS-603)
At minimum, TBS Coach shall be a high school graduate with three years of experience working with children, adolescents and families in group home, hospital, SED designated classroom, day treatment, or other equivalent setting. Waivers from program monitor may be obtained and kept on file (with signature list).

DAY PROGRAMS:

Day Program – Weekly Summary (prompts) (MHS-613A)
MD acting as the primary therapist, licensed or waivered Clinical Psychologist, licensed, registered, or waivered LCSW, licensed, registered or waivered MFT, or RN (with Masters Degree and psychiatric specialty), and Trainees with co-signature by an LPHA or LPHA waived. Rehabilitation Staff, Rehabilitation Specialists, and Para Professional may complete the summary, however it must be reviewed and signed by one of the above.

Day Program – Weekly Summary (MHS-613B)
MD acting as the primary therapist, licensed or waivered Clinical Psychologist, licensed, registered, or waivered LCSW, licensed, registered or waivered MFT, or RN (with Masters Degree and psychiatric specialty), and Trainees with co-signature by an LPHA or LPHA waived. Rehabilitation Staff, Rehabilitation Specialists, and Para Professional may complete the summary, however it must be reviewed and signed by one of the above.

Day Program – Progress Note (MHS-604)
All service providers, acting within the scope of their practice.

Day Intensive Programs are to utilize the MHS-924 or MHS-925 for the weekly psychotherapy requirement, but this session may not be separately billed unless program contract so indicates.

MODE OF COMPLETION:

Legibly handwritten, typed, or word processed on specific progress note form (MHS-926, MHS-925, MHS-924, MHS-604, MHS-613A or MHS-613B, MHS-603).

REQUIRED ELEMENTS:

General Elements
All must include date of service, CPT or HCPCS (with InSyst) Code, DSM-IV-TR Code(s) and corresponding ICD-9-CM Billing Code(s) which is the focus of session, location of service, face to face time (excluding Case Management/Brokerage, Rehab, TBS, and Other Collateral services), total time in minutes, staff signature, printed name, credential and date note was completed. Co-Signature with credential, date, and printed name may be required for trainees by LPHA Supervisor.

Day Programs are claimed as half or full day services and therefore do not require an outline of face to face time or total time. Additionally, Day Program shall utilize the service code for Day Intensive Half or Full (DIH, DIF) and Day Rehabilitation Half or Full (DRH, DRF) rather than a CPT or HCPCS Code.

Group Progress Note (MHS-924)
In addition to the above General Elements, a psychotherapy group note must also include the group formula, provider staff and any co staff ID, client's affect/mood, appearance, and orientation. Any Precipitators or Recent Stressors are to be outlined, as well as safety issues. An overview of the group should include the client's complaints, symptoms, focus of group and interventions utilized by facilitator(s). Progress towards the client's Client Plan goals and objectives is to be outlined in measurable language. If changes to the Client Plan is indicated, and if so outline the plan. Trainees require a co-signature with credential, date and printed name of supervisor.

Day Intensive Program shall fulfill the weekly psychotherapy requirement by providing either a group, family, or individual session. Psychotherapy Groups fulfilling the weekly requirement shall be documented on this form.

Individual / Family Progress Note (MHS-925)
In addition to above General Elements, an individual psychotherapy note must also include the provider's staff ID number. The Current Condition section shall outline the client's complaints, symptoms, appearance, change in cognitive capacity, changes from previous visits, potential for harm if any, any new precipitator and any new strengths. The following sections shall outline the Therapeutic Intervention(s), Client's Response to Treatment, and Progress Toward Client Plan Goal(s) and Objective(s). Plan of Care section shall outline any changes to the Client Plan, what the next steps shall be, and if any referrals were given. Other Information section is made available for any valuable item not otherwise outlined in the note. Trainees require a co-signature with credential, date and printed name of supervisor.

This form shall also capture family sessions, outlining all those present and their contribution and response to interventions.

Day Intensive Program shall fulfill the weekly psychotherapy requirement by providing either a group, family, or individual session. Individual psychotherapy fulfilling the weekly requirement shall be documented on this form.

Progress Note – Other Services (MHS-926)
This format allows for more than one service or contact per client to be outlined on a page. A page may only capture one calendar day. Each entry must outline the above General Elements as well as what was Attempted, Accomplished, Intervention(s) and Response.

Crisis Intervention notes shall indicate acute nature, interventions considered and delivered, client's response to intervention and plan(s) for subsequent services.

Case Management / Brokerage and Rehab Services notes may be a summary of multiple daily contacts. New information or changes in the client's condition or plan must be reflected as it occurs.

Collateral notes shall identify the significant support person(s) participating in the service being documented and describe the purpose related to the client's Client Plan needs. When documenting consultations or team meetings, each billing provider's contribution must be outlined and the overall plan of action.

Non-MD Medication Services (including injections) by an RN, Other Medication Related service, including participation in Team Meeting, Non-Billable Medication Visits, Non Billable Crisis Intervention, Non Billable Individual, Non Billable Case Management, No Show, or Other shall also be captured on the progress note format outlining the service provided. The three digits InSyst Code (and HCPCS Code when applicable) shall be entered in place of a CPT Code.

TBS Progress Note (MHS-603)
In addition to above General Elements, a TBS Progress Note shall specify the client's appearance and any risk factors. Each target behavior addressed shall be identified with specific observation/description of behavior, interventions/review of treatment provided, result/response and plan.

Day Program – Weekly Summary (prompts) (MHS-613A)
Day Program – Weekly Summary (MHS-613B)
Day Program – Progress Note (MHS-604)
Day Programs (both Day Intensive and Day Rehabilitation) shall complete a Weekly Summary (choosing between the MHS-613A or 613B) which identifies the service code, location of service, and DSM-IV-TR and ICD-9-CM Billing Code(s). All dates of attendance shall be outlined with an overall progress towards goals and objectives, specific to what was attempted, accomplished, interventions and responses. Providers shall print name with credentials, sign and date the summary.

Day Intensive Programs shall additionally document a daily progress note on client's activities, outlining what was attempted, accomplished, interventions and responses. Finally, a minimum of one psychotherapy contact per week shall be documented on the MHS-924 or MHS-925.

BILLING:

After rendering a service, the correct progress note form is to be completed adhering to the above documentation standards. A billing record shall be completed for each progress note entry. An Outpatient and Physician-Nurse Billing Record Version is available. The Client's Name, InSyst Number, Service Date, and RU/Program shall be entered in on the T Bar. Each Billing Record shall include the Clinician's Name, Provider Staff ID Number, a Co-Therapist's Name and Provider Staff ID Number when applicable. Number of clients in group when applicable.

Date Billing Record was entered and the Data Entry Staff initials. For new clients enter the DSM-IV-TR Diagnosis Code(s) and the corresponding ICD-9-CM Billing Code(s). For existing clients the DSM-IV-TR and ICD-9-CM Billing Code(s) only need to be completed when there is a change, prompting Data Entry Clerk to enter the change into InSyst. Location of Service is to be identified (office, field, phone, school, satellite, crisis field, jail, inpatient). Staff who provided the service shall sign the Billing Record certifying that they provided the services shown on the record personally, and that the services were medically necessary. The Staff shall identify the correct Provided Service and circle the corresponding InSyst Code. County Program shall enter a CPT Modifier when indicated. Face to Face Minutes shall be documented (unless it is not applicable) as well as Total Minutes. The CPT Code and HCPCS columns on the Billing Record are to assist the staff in completing a Progress Note.

One billing record per calendar day per client by one provider is to be generated. When more than one service is provided it may be documented on the same billing record, excluding Evaluation and Management codes such as 90801, 90862, and 90864.

Day Programs provide an all-inclusive rate and shall capture the billing of all clients enrolled in their program on a given day utilizing their own program's billing record.

Date of Service:	CPT/HCPCS Code:	Location of Service: 1=Office, 2=Field, 3=Phone, 4=Home, 5=School, 6=Satellite, 7=Crisis Field, 8=Jail, 9=Inpatient.
Provider Staff ID:	F/F Time: HR: MIN:	Total Time: HR: MIN:
Focus of session.		
DSM-IV-TR Diagnosis Code(s):		ICD-9-CM Billing Code(s):

Current Condition (include complaints, symptoms, appearance, cognitive capacity, changes from previous visits, potential for harm, precipitators, strengths):

Therapeutic Intervention:

Response to Treatment:

Progress Toward Measurable Goals/Objectives:

Plan of Care (include indicated client plan changes, next steps, referrals given):

Other Information:

Signature/Credential Date Printed Name

Co-Signature/Credential Date Printed Name

Date of Service:	CPT/HCPCS Code:	Location: *	Group Formula (total time is per client) # Minutes X ____ #Staff / ____ # Clients = ____
Provider Staff ID:	Provider Co-Staff ID:	Face to Face Time: HR: MIN:	Total Time: HR: MIN:

Focus of Treatment:

DSM-IV-TR Diagnosis Code(s): ICD-9-CM Billing Code(s):

Affect/Mood: ☐ Appropriate ☐ Flat ☐ Blunted ☐ Elevated ☐ Anxious ☐ Irritable ☐ Depressed ☐ Restricted ☐ Labile ☐ Incongruent ☐ Other: _____

Appearance: ☐ Clean ☐ Disheveled ☐ Malodorous ☐ Well-Nourished ☐ Malnourished ☐ Other: ____

_____

Orientation: ✓=Yes	☐ Person	☐ Place	☐ Time ☐ Day ☐ Month ☐ Year	☐ Current Situation	☐ All Normal

Precipitators/Recent Stressors: ☐ No ☐ Yes Describe:

Safety Issues: ☐ No ☐ Yes Describe:

Review of Group (include client's complaints/symptoms/focus of group/interventions):

Progress Towards Measurable Goals/Objectives:

Changes to Plan of Care Indicated? ☐ **Yes** ☐ **No**

Plan:

Signature/Credential	Date	Printed Name
Co-Signature/Credential	Date	Printed Name

* 1-Office, 2=Field, 3=Phone, 4=Home, 5=School, 6=Satellite, 7=Crisis Field, 8=Jail, 9=Inpatient

County of San Diego - CMHS

Client: _____

InSyst #: _____

Program: _____

GROUP PROGRESS NOTE
HHSA:MHS-924 (3/2005)

FOR EACH CHART ENTRY, PLEASE INCLUDE THE FOLLOWING:

<table>
<tr><td colspan="2">Date of Service:</td><td>CPT/HCPCS Code</td><td>DSM-IV-TR /ICD-9-CM Diagnosis Code(s)</td><td colspan="2">Location of Service: 1=Office 2=Field 3=Phone 4=Home 5=School 6=Satellite 7=Crisis Field 8=Jail 9=Inpatient</td></tr>
<tr><td>Face to face time</td><td>Total time in minutes</td><td colspan="2">Signature/Title/Credential</td><td>Date</td><td>Printed Name</td></tr>
</table>

County of San Diego – CMHS

PROGRESS NOTE – OTHER SERVICES

HHSA:MHS-926 (3/2005)

Client: ______________________

InSyst #: ______________________

Program: ______________________

Date of Service:	HCPCS Code / InSyst Code:	Location of Service:
	H2019HE / (313)	1=Office 2=Field 3=Phone 4=Home 5=School 6=Satellite 7=Crisis Field 8=Jail 9=Inpatient
Staff ID:	Total Time HR: MIN:	Focus of Session: DSM-IV-TR Diagnosis Code(s): _____ ICD-9-CM Billing Code(s): _____

Client Appearance and any Risk Factors:

Target Behavior # 1:

Observation/Describe Behavior:

Intervention/Review of Tx Provided:

Result/Response:

Plan:

Target Behavior # 2:

Observation/Describe Behavior:

Intervention/Review of Tx Provided:

Result/Response:

Plan:

Continue on back

Target Behavior # 3:
Observation/Describe Behavior:
Intervention/Review of Tx Provided:
Result/Response:
Plan:
Target Behavior # 4:
Observation/Describe Behavior:
Intervention/Review of Tx Provided:
Result/Response:
Plan:
Comments/Other:
Print Name, Title:
Signature:
Date:

Service Code: DIF DIH DRF DRH	Location of Service: All services were offered on site, unless otherwise specified.	**WEEKLY SUMMARY**	DSM-IV-TR Diagnosis Code(s) ICD-9-CM Billing Code(s):

Service Components	Monday	Tuesday	Wednesday	Thursday	Friday
Individual Therapy					
Family Therapy					
Group Therapy					
Therapeutic Milieu					
Community Meeting					

***Day Treatment Intensive Programs require a daily progress note on client's activities.

OVERALL PROGRESS TOWARDS GOALS AND OBJECTIVES

Significant Weekly Information:

Goal #1:

Interventions and Progress Towards Client Plan Goal:

Goal #2:

Interventions and Progress Towards Client Plan Goal:

Print Name: Signature: Credentials: Date:

Client: _____

InSyst #: _____

Program: _____

WEEKLY SUMMARY

Day Treatment Intensive Programs require a daily progress note on client's activities.

Service Code:	Location of Service:	DSM-IV-TR Diagnosis Code(s)	ALL DATES of Attendance with Year:
DIF DIH DRF DRH	All services were offered on site, unless otherwise specified.	ICD-9-CM Billing Code(s):	

Print Name: **Signature:** **Credentials:** **Date:**

DAY PROGRAM - PROGRESS NOTE

Location of Service: Offered on site, unless otherwise specified.

At the beginning of each note include:
Service Code (DIF DIH DRF DRH), and Date of service.

At end of each note include:
Printed Name, Credentials (or title), Signature, Date note was completed.

County of San Diego - CMHS
Health and Human Services Agency

BILLING RECORD (3/2005)
Outpatient Version

Client: _____
InSyst #: _____
Program: _____
Service Date: _____

(Print)

Clinician's Name:	Provider Staff ID #:	Co-Therapist's Name:	Provider Staff ID #:	# Clients in Group:	Date BR Entered:	Data Entry Initials:

Complete this section if Dx changed
DSM-IV-TR Diagnosis Code(s): _____ _____
ICD-9-CM Billing Code(s): _____ _____

Location of Service (Check One)
☐ 1 = Office ☐ 3 = Phone ☐ 5 = School ☐ 7 = Crisis Field
☐ 2 = Field ☐ 4 = Home ☐ 6 = Satellite ☐ 8 = Jail
☐ 9 = Inpatient

I certify that the services shown on this sheet were provided by me personally, and the services were medically necessary. _____ Clinician Signature

Provider Service	InSyst Code	AB2726	CPT Code	HCPCS	CPT Modifier	Face to Face Minutes	Total Minutes
MENTAL HEALTH SERVICES							
Assessment	801	701	90801	H2015HE			
Individual (up to 44 min. face-to-face)	804	704	90804	H2015HE			
Individual (45-74)	806	706	90806	H2015HE			
Individual (75-90)	808	708	90808	H2015HE			
Family Therapy without Client	846	746	90846	H2015HE			
Family Therapy with Client	847	747	90847	H2015HE			
Multiple-Family Therapy	849	749	90849	H2015HE			
Other Collateral (including Team Meeting)	310	311	N/A	H2015HE		N/A	
Group Psychotherapy	853	753	90853	H2015HE			
Rehab Services	535	N/A	N/A	H2015HE		N/A	
Case Management/Brokerage	501	512	N/A	T1017HE		N/A	
INTERACTIVE MENTAL HEALTH SERVICES							
Assessment-Interactive	802	702	90802	H2015HE			
Individual Interactive (up to 44)	810	710	90810	H2015HE			
Individual Interactive (45-74)	812	712	90812	H2015HE			
Individual Interactive (75-90)	814	714	90814	H2015HE			
Group Psychotherapy -Interactive	857	757	90857	H2015HE			
OTHER SERVICES							
Crisis Intervention	370	371	N/A	H2011HE		N/A	
Psychological Testing	835	735	96100	H2015HE			
Assessment of Aphasia	836	736	96105	H2015HE			
Developmental Testing	837	737	96110	H2015HE			
Extended Development Testing	838	738	96111	H2015HE			
Neurobehavioral Status Exam	839	739	96115	H2015HE			
Neuropsychological Testing Battery	840	740	96117	H2015HE			
Review of Records (Assessment)	885	785	90885	H2015HE			
Interpretation of Exams/Data	887	787	90887	H2015HE			
Report Preparation	889	789	90889	H2019HE			
TBS	313	N/A	N/A	H2019HE		N/A	
No Show*	299	N/A	N/A	N/A		N/A	
Non Billable Mental Health Services *	899	799	90899	N/A		N/A	
Non Billable Case Management*	560	515	N/A	N/A		N/A	
Non Billable Crisis Intervention*	218	216	N/A	N/A		N/A	
Other**							

CPT & HCPCS Modifiers (Indicate on line of service. Only for use by County programs …)

21 Prolonged E & M	22 Unusual Procedural Services	52 Reduced Service

* Coding is required when a direct non-billable client service occurs.
**NOTE: This is not an all-inclusive list. Use this space to list other procedure codes not listed above.

CONFIDENTIAL PATIENT INFORMATION
See California W and I Code, Section 5328 - Fed. Regs. 42 CFR Part 2

County of San Diego - CMHS
Mental Health Services

BILLING RECORD (3/2005)
Physician – Nurse Version

Client: _____
InSyst #: _____
Program: _____
Service Date: _____

(Print)

Clinician's Name:	Provider Staff ID#:	Co-Therapist's Name:	Provider Staff ID#:	# Clients in Group:	Date BR Entered:	Data Entry Initials:

Complete this section if Dx changed
DSM-IV-TR Diagnosis Code(s): _____
ICD-9-CM Billing Code(s): _____

Location of Service (Check One)
☐ 1 = Office ☐ 3 = Phone ☐ 6 = Satellite ☐ 8 = Jail
☐ 2 = Field ☐ 4 = Home ☐ 5 = School ☐ 7 = Crisis Field
☐ 9 = Inpatient

I certify that the services shown on this sheet were provided by me personally, and the services were medically necessary. _____ Clinician Signature

Physician or Nurse Service	InSyst Code	AB2726	CPT Code	HCPCS	Modifier	Face to Face Minutes	Total Minutes
MEDICATION SERVICES							
Pharmacological Management, including prescription, use and review of medication with no more than minimal medical psychotherapy. (physician only)	862	762	90862	H2010HE			
Brief Office Visit for the sole purpose of monitoring or changing drug prescriptions. (physician only)	864	764	M0064	H2010HE			
Physician Educational Services: physician educational services rendered to patients in a group setting. (physician or nurse)	878	778	99078	H2010HE			
Non-MD Medication (Including injections): Comprehensive med services. (nurse)	362	388	N/A	H2010HE		N/A	
Other Medication Related service, including participation in team meeting where meds are discussed or considered for named client, review of records, etc. (physician only)	860	760	N/A	H2010HE		N/A	
Non-Billable Medication Visit*	214	215	N/A	N/A		N/A	
OTHER SERVICES: For services not related to medication, report on non-physician billing record. Claimed at a lower rate.							
No Show*	299	N/A	N/A	N/A		N/A	
Other**							

CPT & HCPCS Modifiers (Indicate on line of service. Only for use by County programs)

21 Prolonged E & M	22 Unusual Procedural Services	52 Reduced Service

* Coding is required when a direct non-billable client service occurs.
**NOTE: This is not an all-inclusive list. Use this space to list other procedure codes not listed above.

SECTION VI

MEDICAL

MEDICATION PROFILE

WHEN:	Each time a medication is prescribed, dispensed, administered, or discontinued.
ON WHOM:	All clients for whom psychotropic medication is prescribed, administered, or discontinued.
COMPLETED BY:	MD / DO / RN / LVN
MODE OF COMPLETION:	Legibly handwritten, typed, or word-processed on Medication Profile form (MHS-913).
REQUIRED ELEMENTS:	At the top of the form note any known allergies, physical problems, and client's diagnosis. Noting the client's Date of Birth, address, pharmacy name, and phone number is optional. Date medication is prescribed or discontinued. Medication name (with dosage and frequency), amount prescribed, any refills, and the name of the prescribing physician. Make a separate entry when discontinuing a medication, including date and reason. T Bar shall be completed with the client's name, InSyst number, and program name.
BILLING:	After rendering a service, the appropriate progress note format shall be completed documenting the services rendered (see medical progress notes section for MHS 645 or MHS 689 form). The treating physician shall complete the Physician-Nurse Billing Record (See Billing portion of Progress Note section).

Allergies: _____

Physical Problems: _____

Diagnosis: _____

_____

Client's DOB: _____

Client's Address: _____

_____

Pharmacy: _____ Phone: _____

Date	Medication, dose amount, and frequency *make a separate entry when discontinuing medication, including date and reason.	Amount Prescribed	Refills	Prescribing MD Name

County of San Diego – CMHS

MEDICATION PROFILE
HHSA:MHS-913 (3/2005)

Client: _____

InSyst #: _____

Program: _____

INFORMED CONSENT FOR THE USE OF PSYCHOTROPIC MEDICATION

WHEN: Whenever psychotropic medication is prescribed.

ON WHOM: All clients receiving psychotropic medication.

COMPLETED BY: MD / DO

MODE OF COMPLETION: Legibly handwritten on Informed Consent for the Use of Psychotropic Medication form (MHS-005).

REQUIRED ELEMENTS: State law defines informed consent as the voluntary consent by the client (or legal guardian) to take psychotropic medication after the physician has reviewed the following:

- Explanation of the nature of the psychiatric problem and why psychotropic medication is being recommended.
- The general class (antipsychotic, antidepressant, etc.) of medication being prescribed.
- The dose, frequency and administration route of the medication being prescribed.
- The risks and benefits of the medication being prescribed. All current FDA and manufactures Black Box warnings related to the prescribed medications should be given.
- What situations, if any, warrant taking additional medications.
- How long it is expected that the client will be taking medication.
- Whether there are reasonable treatment alternatives.
- Client/guardian must sign and date the form, or have M.D. document verbal consent by client/guardian (receipt of verbal consent and documentation should be witnessed by another person who would make a notation on the form with their full name, signature, credentials/title, date and time).
- M.D. must sign, date, and print name.
- A new consent form is to be completed:
    - When a new or different class of medication is prescribed.
    - When the client resumes taking medication following a documented withdrawal of consent.
- T Bar shall be completed with the client's name, InSyst number, and program name.

Clients who are 18 years of age or older or emancipated may consent for their own treatment. Additionally, under some circumstances a minor 12 years and older may consent for their own treatment (see Welfare and Institutions Code 14010 and Family Code 6924, 6929, 7050).

Consent is effective until terminated or for a maximum of one calendar year from date of consent, whichever is earlier.

BILLING:

Completing the consent form and reviewing consent information is often done as part of the session. After rendering a service, the correct progress note form is to be completed according to specific documentation standards. A billing record shall be completed for each progress note entry. See the Billing section of the Progress Note for specific billing instructions.

DEPENDENTS & WARDS:

An ex-parte or court order from the courts may be utilized to authorize use of psychotropic medication. An Application for Order for Psychotropic Medication – Juvenile form (JV-220 January 1, 2001) may be utilized. An Opposition to Application for Order for Psychotropic Medication – Juvenile (JV-220A January 1, 2001) may be filed. The order for authorization is effective until terminated or modified by court order or until 180 days from date of order, whichever is earlier. The forms can be found at **www.USCourtForms.com** and are to be signed by a Judge.

NOTE:

Medication Information Sheets can be obtained on different web sites such as: www.fda.gov

INFORMED CONSENT FOR THE USE OF PSYCHOTROPIC MEDICATION

Client Information and Consent (Please read this form carefully and completely)

- You have the right to be informed; be given information about your care and to ask questions.
- You have the right to accept or reject all or any part of your care plan.
- You have the right to revoke consent verbally or in writing to any member of the treating staff for any reason at any time.
- You have the right to language/interpreting services. Services Requested: ☐ YES ☐ NO
- You have the right to a copy of this Consent: Copy Requested? ☐ YES ☐ NO

Emergency Treatment: In certain emergencies, medication may be given to you when it is impractical to obtain consent. However, once the emergency has passed, medication will continue with your informed consent. *(An emergency is a temporary, sudden marked change requiring action to preserve life or prevent serious bodily harm to client or others).*

Your Physician is prescribing the following psychotropic medication(s) for you:

Medication(s) Name	Medication Info. Sheet Given (check box) ☑
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO

In order to be informed and give consent, your doctor will discuss the following information with you:

Verbal Information Discussed with Client

1. Nature and seriousness of your mental illness
2. Reason(s) for medication(s) including the likelihood of improving, or not improving with or without the medication(s)
3. Reasonable alternative treatments and why doctor is recommending this particular treatment
4. Type, range of frequency and amount (including PRN orders), method (oral or injection), duration of taking medication(s)
5. Probable side effects known to commonly occur, and any particular side effects likely to occur with you
6. Possible additional side effects which may occur when taking medication(s) beyond three months
7. If prescribed a ***conventional/typical or atypical antipsychotic medication,*** information will be given to you about **tardive dyskinesia,** a possible side effect caused by ***typical/atypical antipsychotic medication.*** It is characterized by involuntary movements of the face or mouth and/or hands and feet. These symptoms are potentially irreversible and may appear after medication has been discontinued.

Client: _____

InSyst #: _____

Program: _____

Client's Consent:

Based upon the information I have read, discussed and/or reviewed with my doctor:
(check one of the following)

- ☐ I understand and give consent to the use of the psychotropic medication(s) on page one.
- ☐ I give verbal consent only; refuse to sign form.
- ☐ I do not approve/consent to the use of the psychotropic medication(s) listed below.

Please list: _____

_____

Signature of Client/Legal Rep./Guardian Date

Doctor's Statement:

I have reviewed, discussed and recommend the medication plan (page 1) for above client and:

- ☐ Client gives consent to take these medications.
- ☐ Client gives verbal consent, but unwilling or unable to sign.
- ☐ Emergency. Given medication without consent.
- ☐ Unable to understand risks and benefits, and therefore cannot consent.
- ☐ Other Comments: _____

_____

_____

Psychiatrist's Signature Date

_____

Printed Name

_____

Witness Signature (if applicable): Date

ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name and Address)*:	*FOR COURT USE ONLY*
TELEPHONE NO. *(Optional)*: FAX NO. *(Optional)*: E-MAIL ADDRESS *(Optional)*: ATTORNEY FOR *(Name)*:	
SUPERIOR COURT OF CALIFORNIA, COUNTY OF STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
CHILD'S NAME:	☐ Attachments
APPLICATION FOR ORDER FOR PSYCHOTROPIC MEDICATION—JUVENILE	CASE NUMBER:

1. The child is a ☐ dependent ☐ ward of the court under Welfare and Institutions Code section ☐ 300 ☐ 601 ☐ 602, and was removed from the custody of his or her parent or guardian on *(date)*:
2. Child's date of birth: Child's weight:
3. The child is currently placed in:
   ☐ relative's home ☐ foster home ☐ group home ☐ juvenile hall ☐ camp
   ☐ other (*specify*):
4. Applicant is ☐ child's treating physician ☐ social worker on behalf of physician ☐ probation officer on behalf of physician ☐ Letter or Declaration by Physician included as Attachment 4.
   a. Name of treating physician:
   b. Address and phone number of treating physician:
   c. Employer of physician:
   d. Medical specialty of physician:
   e. Board eligibility/certification:
   f. Date of evaluation of child:
   g. Location of evaluation:
5. Applicant requests the court to:
   a. ☐ authorize the administration to the child of the psychotropic medication(s) described in section 9 below; or
   b. ☐ authorize *(name and address)*:

   who is the child's ☐ mother ☐ statutorily presumed father ☐ legal guardian as established by the Probate or Juvenile Court, to consent to the administration of the psychotropic medication(s) described in section 9 below. The child's parent or legal guardian poses no danger to the child and has the capacity to authorize the administration of the medication(s) *(describe bases for this statement)*:

   ☐ Continued on Attachment 5.
6. The child has been diagnosed as suffering from the following mental disorder(s) *(state DSM–IV Diagnosis [Axes I to III])*:

   ☐ Continued on Attachment 6.

Form Adopted for Mandatory Use
Judicial Council of California
JV-220 [New January 1, 2001]

APPLICATION FOR ORDER FOR PSYCHOTROPIC MEDICATION—JUVENILE